Arizona Department of Health Services

2009 J-1 VISA WAIVER PROGRAM
Request For Letter Of Support
SERVICE SITE/EMPLOYER APPLICATION

J-1 PHYSICIAN _____

Last Name First Name Middle Initial (DOS Case Number)

SERVICE SITE _____

ADDRESS: _____

Street Suite#

_____ _____ _____

City County Zip

PHONE NUMBER: **( )** _____ **FAX**: ( ) _____

E-MAIL: _____

IS SERVICE SITE A:

☐ Federally Qualified Health Center (FQHC) or FQHC Look-Alike (Social Security Act § 1905(I)(2))B)

☐ Rural Health Clinic (Rural Health Clinic Services Act (PL 95-210)

☐ Arizona Primary Care Program (PCP) Clinic (Has a contract with ADHS for provision of Primary Care Services to uninsured in Arizona)

☐ None of the above

NAME OF ADMINISTRATOR: _____

NAME OF THE FEDERALLY DESIGNATED AREA IN WHICH THE SERVICE SITE IS LOCATED:

Health Professional Shortage Area (HPSA): _____

Medically Underserved Area or Population (MUA / MUP): _____

County: _____

DISTANCE from this site to the nearest referenced* clinic that offers a sliding discount to fee scale for services: Site Name: _____ #_____ miles. *See: Arizona Sliding Fee Schedule clinics map at www.azdhs.gov/hsd/sfs_provider.htm

IMPORTANT: THE SITE LISTED ABOVE WILL BE THE APPROVED SERVICE SITE. IF APPLICABLE COMPLETE A SEPARATE SERVICE SITE APPLICATION FOR EACH ADDITIONAL SERVICE SITE.

EMPLOYER (if different from the service site):

NAME: _____

MAILING ADDRESS: _____

Street City State - Zip

PHONE NUMBER: ( )_____ **FAX**: ( ) _____

E-MAIL: _____

NAME OF ADMINISTRATOR: _____

TYPE OF EMPLOYER

☐ Public ☐ Private

☐ Non-Profit ☐ For-Profit

SERVICE SITE PROOF OF SERVICES

TOTAL ENCOUNTERS(1) PER YEAR (2)	**2006****	**2007*****
A. TOTAL # ENCOUNTERS AT THE SERVICE SITE		
B. TOTAL # MEDICARE ENCOUNTERS		
C. TOTAL # MEDICAID(3) ENCOUNTERS		
D. TOTAL # SFS(4) ENCOUNTERS		
E. TOTAL # ENCOUNTERS FREE OF CHARGE		
F. C + D + E		
G. F / A * 100 (% of underserved patients served		

(1) An encounter is an office visit with a patient.
(2) All encounters must have been at the specific facility referred to in this application.
(3) Number of visits where patients used AHCCCS or KidsCare as a method of payment.
(4) Number of visits using a Sliding Fee Schedule.

Fill out accordingly:
**If in existence for 2 or more years
***If in existence 6 months to one year

2009 PROGRAM EXPECTATIONS FOR THE SERVICE SITE/EMPLOYER

A. The Service Site Understands and Agrees To:

This service site has been in operation since _____, and:

- Has attempted to employ a U.S. citizen provider. Recruitment documentation efforts attached.
- Has the financial means available to support the provider, including salary, benefits, and malpractice insurance expenses, for a minimum of 36 months.
- Will employ the J-1 physician to provide full-time primary care or psychiatric services or the approved specialty services at this site.
- The undersigned certifies that the Service Site will accept walk-in patients.
- Is not an appointment only practice.
- The undersigned certifies that the Service Site will accept Medicare, AHCCCS (AZ Medicaid), and State Children's Health Insurance program (SCHIP) assignment rates and to treat patients regardless of the patient's ability to pay
- The undersigned certifies that the Service Site will offer a sliding fee schedule for all eligible patients at the Service Site based on the patient's ability to pay. The Sliding Fee Schedule is based on current Department of Health and Human Services Poverty Guidelines as published in the Federal Register. Will submit for ADHS review and approval a current Service Site sliding fee schedule, on office letterhead, **and** the procedure for its use at the site for each year of the physician's obligation under a J-1 Visa Waiver.

  (Attach a copy of the Service Site sliding fee schedule **and** the office procedure for its use)
- Will ensure that an Encounter Report (www.azdhs.gov/hsd/visa_waiver.htm) is submitted, by the J-1 physician, on a calendar quarterly basis after the start of the physician's obligation to ADHS for the same calendar quarter. This form indicates the Service Site's sliding discount to fee scale utilization by the J-1 physician.
- Will report the official start date, in writing, of the J-1 physician within 7 calendar days of start.
- Will notify the Arizona Department of Health Services (ADHS) of the J-1 physician's local address and phone number.
- Will notify the ADHS immediately, in writing, if the physician fails to report to the service site or the employment agreement is severed at anytime during the J-1's obligation.
- Will notify the ADHS, in writing, and submit a complete transfer packet (provided by the program) before transferring the physician to another location.

I certify that, to the best of my knowledge and belief, all data provided in this application is true and correct.

_____

(Signature of Executive Director/Administrator
or Authorized Signatory at Service Site or Employer*)

State of Arizona_____)

County of_____)

Subscribed and sworn (or affirmed)
before me this ____ day of _____20____

(seal) _____.
Notary Public
*If non-service site employer